

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

07261

7286

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RED #1 Woodbine</u>				c. LENGTH OF STAY IN 1b <u>3 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural R.E.D #1 Woodbine, Md.</u>			
				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>A</u> Last <u>ADDISON</u>				4. DATE OF DEATH Month <u>7</u> Day <u>18</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Tygero</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN ? 1980</u>	9. AGE (In years last birthday) yrs. <u>76</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Charles Addison</u>				14. MOTHER'S MAIDEN NAME <u>MARIA Belle Addison</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>770</u>		16. SOCIAL SECURITY NO. <u>577-24-4465</u>		17. INFORMANT Address <u>Mrs Rosta Harrison</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest, Arteriosclerosis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Heart disease, Coronary thrombosis,</u> DUE TO (c) <u>Cerebral hemorrhage</u>						INTERVAL BETWEEN ONSET AND DEATH <u>11 July 56 to 18 July 56</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>11 July</u> , 19 <u>56</u> , to <u>18 July</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>17 July</u> , 19 <u>56</u> , and that death occurred at <u>5:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Howard E. Hall</u> M.D.				ADDRESS (Street, city or town, state) <u>Sykesville, Md.</u> DATE SIGNED <u>18 July 56</u>			
PHYSICIAN'S NAME (Type) <u>Howard E. Hall</u>				<u>Sykesville, Md.</u> <u>18 July 56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 20, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bushy Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Howard County Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. M. Waltz Wingfield, Md.</u>				ADDRESS <u>10120 1956</u>		24b. REGISTRAR'S SIGNATURE <u>A. H. Hendrich</u>	



7287

## CERTIFICATE OF DEATH

Reg. Dist. No.

190

1. PLACE OF DEATH a. COUNTY <b>Howard</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkridge</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkridge</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1700 Levering Ave</b>		d. STREET ADDRESS <b>1700 Levering Ave</b>	
3. NAME OF DECEASED (Type or print) First <b>Annie</b> Middle <b>Bell</b> Last <b>Blank</b>		4. DATE OF DEATH Month <b>July</b> Day <b>25</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 17, 1887</b>
9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	IF UNDER 24 HRS. Hours <b>0</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>
12. CITIZEN OF WHAT COUNTRY? <b>US</b>		13. FATHER'S NAME <b>August Blank</b>	
14. MOTHER'S MAIDEN NAME <b>Rose Ella James</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>August Blank Jr. 1700 Levering Ave Elkridge</b>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Constrictive Cardiac Failure</b> <b>422.1</b> DUE TO <b>arterio-sclerotic Cardio-Vasc. Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>calcific stenosis mitral + aortic valves</b> DUE TO <b>arteriosclerosis</b> (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>1 mo.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>chronic Hemoglobinosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>o. p.</b> <b>19</b> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>400 N. Hilton St.</b>
20f. (City or town) <b>Baltimore</b>		(County) <b>Howard</b>
21. I certify that I attended the deceased from <b>5/1</b> , 19 <b>56</b> , to <b>7/25</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>July 20</b> , 19 <b>56</b> , and that death occurred at <b>4:00 PM</b> , from the causes and on the date stated above.		
ACTUAL SIGNATURE <b>Kenneth Krulovitz</b> M.D.		DATE SIGNED <b>7/26/56</b>
PHYSICIAN'S NAME (Type) <b>Kenneth Krulovitz, M.D.</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7-29-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>
22d. LOCATION (City, town, or county) <b>Baltimore Md.</b>		(State) <b>Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard, 4107 Wilkens Ave. 29</b>		24b. REGISTRAR'S SIGNATURE <b>E. Bird Williams</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

## CERTIFICATE OF DEATH

BUREAU V. S.

JUL 31 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 187263

7288

CERTIFICATE OF DEATH

Reg. Dist. No. 190

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Howard</u>	MARYLAND	STATE <u>md</u>	COUNTY <u>Howard</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Elkridge (Howard)</u>	LENGTH OF STAY (In this place) <u>Life</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Elkridge (Howard)</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2109 London Ave</u>		STREET ADDRESS (If rural give location) <u>2109 London Ave</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>Charles</u>	(Middle) <u>Benjamin</u>	(Last) <u>Bosen</u>	DATE OF DEATH: <u>July 14</u> 19 <u>56</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Oct 23-1897</u>
9. AGE last birthday <u>58</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist B &amp; O R.R.</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Elkridge Md</u>	
11. BIRTHPLACE (State or foreign country): <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Benjamin C. Bosen</u>		14. MOTHER'S MAIDEN NAME: <u>Margaret E. Bennett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>705-05-3429</u>	
17. INFORMANT & ADDRESS: <u>Mrs Margaret E. Bosen wife 2109 London Ave, Elkridge 27 Md</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		6 mo	
IMMEDIATE CAUSE (A) <u>Myocarditis, chr 2</u>			
ANTECEDENT CAUSE (B) <u>Pulmonary emphysema 1 wk</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Left Hemiplegia 4 wk</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>General arteriosclerosis 3 yrs</u>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
		<u>Encephaloma 10 yrs</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>March 1956</u> , to <u>July 14, 1956</u> , that I last saw the deceased alive on <u>July 13, 1956</u> , and that death occurred at <u>6:25 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>B. B. Brumbaugh</u>		DATE SIGNED <u>7/14/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7/17/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Meadowridge Mem. Pk.</u>		LOCATION (City, town, or county) (State) <u>Howard Co., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-16-56</u>		REGISTRAR'S SIGNATURE <u>Dr. J. J. Dickner</u>	
		24. FUNERAL DIRECTOR <u>Dr. J. J. Dickner &amp; Sons - Bacto 17 Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



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## CERTIFICATE OF DEATH

67264

Reg. Dist. No. 191

1. PLACE OF DEATH o. COUNTY <b>Ellicott City, Howard Maryland</b>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Highland Manor Nursing Home</b>				d. STREET ADDRESS <b>822 Hillman Court</b>			
3. NAME OF DECEASED (Type or print) First <b>David</b> Middle <b>John</b> Last <b>Burch, Sr.</b>				4. DATE OF DEATH Month <b>July</b> Day <b>26</b> Year <b>1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 30, 1869</b>	9. AGE (In years last birthday) <b>87</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Phila. Quart Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Arthur Adam Burch</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>Span.-Amer. 215-09-1839</b>		17. INFORMANT <b>Charles W. Munch</b> Address <b>1206 Weldon Ave. (11)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis, generalized</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED White <input type="checkbox"/> Nat white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>5/20</b> , 19 <b>56</b> , to <b>7/26</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>7/20</b> , 19 <b>56</b> , and that death occurred at <b>M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Wm. J. Smith</b>				ADDRESS (Street, city or town, state) <b>5226 Balt. Not. Bldg.</b> DATE SIGNED <b>7/27/56</b>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-30-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc.</b> ADDRESS <b>1217 St. Paul Street</b>				24a. REC'D BY REGISTRAR DATE <b>7/30/56</b>		24b. REGISTRAR'S SIGNATURE <b>J. E. Loughery</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Date of Death		Place of Death	
July 31, 1956		Baltimore, Maryland	
Age		Sex	
67		Male	
Race		Marital Status	
White		Married	
Occupation		Cause of Death	
Retired		Heart Disease	
Place of Birth		Date of Birth	
Maryland		July 31, 1889	
Signature of Physician		Signature of Registrar	
[Signature]		[Signature]	

BUREAU Y. 3

JUL 31 1956

RECEIVED

1517 St. Paul Street  
Baltimore, Md.  
July 31, 1956



7290

## CERTIFICATE OF DEATH

Reg. Dist. No.

190

1. PLACE OF DEATH o. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elbridge</u>		c. LENGTH OF STAY IN 1b <u>50 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elbridge</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1935 Railroad Ave</u>			
3. NAME OF DECEASED (Type or print) <u>Martha</u> First <u>R. Chaney</u> Middle <u>E. Chaney</u> Last				4. DATE OF DEATH Month <u>7</u> Day <u>24</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 6, 1882</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework at home</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>William Reigle</u>				14. MOTHER'S MAIDEN NAME <u>Frances Shaw</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Martha E. Chaney</u> Address <u>1935 Railroad Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chor Myocarditis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General Arteriosclerosis</u> DUE TO <u>5 yrs</u> (c) <u>Senility</u> DUE TO <u>5 yrs</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mal nutrition</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March</u> , 19 <u>56</u> , to <u>July 24</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>July 24</u> , 19 <u>56</u> , and that death occurred at <u>6 P.</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. B. Beumbarch</u> M.D.				ADDRESS (Street, city or town, state) <u>4609 E. Elbridge St Elbridge 27 Md</u> DATE SIGNED <u>7/24/56</u>			
PHYSICIAN'S NAME (Type) <u>A. B. Beumbarch</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>buried</u>		22b. DATE THEREOF <u>July 27, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Cem. Worsey Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Brown</u> ADDRESS <u>Long 401 E. Elbridge St</u>				24a. RECEIVED BY REGISTRAR <u>66</u> DATE <u>7/26/56</u>		24b. REGISTRAR'S SIGNATURE <u>E. Bird Halling</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

21.

BUREAU V. S.

JUL 26 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08368

7291

## CERTIFICATE OF DEATH

Reg. Dist. No.

195

<b>1. PLACE OF DEATH</b> o. COUNTY <u>Howard</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Scaggsville</u>		c. LENGTH OF STAY IN 1b <u>50 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Scaggsville</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Nellie</u> Middle <u>Giddings</u> Last <u>Giddings</u>				<b>4. DATE OF DEATH</b> Month <u>July</u> Day <u>29</u> Year <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 12, 1879</u>		9. AGE (In years, last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Sidell</u>				14. MOTHER'S MAIDEN NAME <u>Laura Padgett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Alfred Giddings Laurel Md</u> Address			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Dis.</u> <u>600.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Nephritis</u> DUE TO (c) <u>Myocardial Insufficiency</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Bronchitis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u> <u>20 yrs</u> <u>1 day</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/29</u> , 19 <u>56</u> , to <u>7/29</u> , 19 <u>56</u> that I last saw the deceased alive on <u>7/29</u> , 19 <u>56</u> , and that death occurred at <u>5:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>B. P. Warren</u> M.D.				ADDRESS (Street, city or town, state) <u>Laurel Md</u> DATE SIGNED <u>7/29/56</u>			
PHYSICIAN'S NAME (Type) <u>B. P. Warren</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/31/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Emmanuel Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Scaggsville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. With Canallan Laurel Md</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>8/6/56</u>			
				24b. REGISTRAR'S SIGNATURE <u>Frank Shipley</u>			

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>	
<p>9. DATE OF DEATH</p>		<p>10. TIME OF DEATH</p>		<p>11. PLACE OF DEATH</p>		<p>12. SIGNATURE OF DECEASED</p>	
<p>13. SIGNATURE OF WITNESS</p>		<p>14. SIGNATURE OF DECEASED</p>		<p>15. SIGNATURE OF DECEASED</p>		<p>16. SIGNATURE OF DECEASED</p>	
<p>17. SIGNATURE OF DECEASED</p>		<p>18. SIGNATURE OF DECEASED</p>		<p>19. SIGNATURE OF DECEASED</p>		<p>20. SIGNATURE OF DECEASED</p>	
<p>21. SIGNATURE OF DECEASED</p>		<p>22. SIGNATURE OF DECEASED</p>		<p>23. SIGNATURE OF DECEASED</p>		<p>24. SIGNATURE OF DECEASED</p>	
<p>25. SIGNATURE OF DECEASED</p>		<p>26. SIGNATURE OF DECEASED</p>		<p>27. SIGNATURE OF DECEASED</p>		<p>28. SIGNATURE OF DECEASED</p>	
<p>29. SIGNATURE OF DECEASED</p>		<p>30. SIGNATURE OF DECEASED</p>		<p>31. SIGNATURE OF DECEASED</p>		<p>32. SIGNATURE OF DECEASED</p>	
<p>33. SIGNATURE OF DECEASED</p>		<p>34. SIGNATURE OF DECEASED</p>		<p>35. SIGNATURE OF DECEASED</p>		<p>36. SIGNATURE OF DECEASED</p>	
<p>37. SIGNATURE OF DECEASED</p>		<p>38. SIGNATURE OF DECEASED</p>		<p>39. SIGNATURE OF DECEASED</p>		<p>40. SIGNATURE OF DECEASED</p>	
<p>41. SIGNATURE OF DECEASED</p>		<p>42. SIGNATURE OF DECEASED</p>		<p>43. SIGNATURE OF DECEASED</p>		<p>44. SIGNATURE OF DECEASED</p>	
<p>45. SIGNATURE OF DECEASED</p>		<p>46. SIGNATURE OF DECEASED</p>		<p>47. SIGNATURE OF DECEASED</p>		<p>48. SIGNATURE OF DECEASED</p>	
<p>49. SIGNATURE OF DECEASED</p>		<p>50. SIGNATURE OF DECEASED</p>		<p>51. SIGNATURE OF DECEASED</p>		<p>52. SIGNATURE OF DECEASED</p>	
<p>53. SIGNATURE OF DECEASED</p>		<p>54. SIGNATURE OF DECEASED</p>		<p>55. SIGNATURE OF DECEASED</p>		<p>56. SIGNATURE OF DECEASED</p>	
<p>57. SIGNATURE OF DECEASED</p>		<p>58. SIGNATURE OF DECEASED</p>		<p>59. SIGNATURE OF DECEASED</p>		<p>60. SIGNATURE OF DECEASED</p>	
<p>61. SIGNATURE OF DECEASED</p>		<p>62. SIGNATURE OF DECEASED</p>		<p>63. SIGNATURE OF DECEASED</p>		<p>64. SIGNATURE OF DECEASED</p>	
<p>65. SIGNATURE OF DECEASED</p>		<p>66. SIGNATURE OF DECEASED</p>		<p>67. SIGNATURE OF DECEASED</p>		<p>68. SIGNATURE OF DECEASED</p>	
<p>69. SIGNATURE OF DECEASED</p>		<p>70. SIGNATURE OF DECEASED</p>		<p>71. SIGNATURE OF DECEASED</p>		<p>72. SIGNATURE OF DECEASED</p>	
<p>73. SIGNATURE OF DECEASED</p>		<p>74. SIGNATURE OF DECEASED</p>		<p>75. SIGNATURE OF DECEASED</p>		<p>76. SIGNATURE OF DECEASED</p>	
<p>77. SIGNATURE OF DECEASED</p>		<p>78. SIGNATURE OF DECEASED</p>		<p>79. SIGNATURE OF DECEASED</p>		<p>80. SIGNATURE OF DECEASED</p>	
<p>81. SIGNATURE OF DECEASED</p>		<p>82. SIGNATURE OF DECEASED</p>		<p>83. SIGNATURE OF DECEASED</p>		<p>84. SIGNATURE OF DECEASED</p>	
<p>85. SIGNATURE OF DECEASED</p>		<p>86. SIGNATURE OF DECEASED</p>		<p>87. SIGNATURE OF DECEASED</p>		<p>88. SIGNATURE OF DECEASED</p>	
<p>89. SIGNATURE OF DECEASED</p>		<p>90. SIGNATURE OF DECEASED</p>		<p>91. SIGNATURE OF DECEASED</p>		<p>92. SIGNATURE OF DECEASED</p>	
<p>93. SIGNATURE OF DECEASED</p>		<p>94. SIGNATURE OF DECEASED</p>		<p>95. SIGNATURE OF DECEASED</p>		<p>96. SIGNATURE OF DECEASED</p>	
<p>97. SIGNATURE OF DECEASED</p>		<p>98. SIGNATURE OF DECEASED</p>		<p>99. SIGNATURE OF DECEASED</p>		<p>100. SIGNATURE OF DECEASED</p>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

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# STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1, Film G200 7-16-56 et

## CERTIFICATE OF DEATH

07266

Reg. Dist. No.

191

7292

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elliott City</u>		c. LENGTH OF STAY IN 1b <u>60 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City, 12 3V01-4</u>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Taylor Manor Hospital</u>		d. STREET ADDRESS <u>1247 Winston Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Annelle</u> First Middle <u>Gilliland</u> Last		4. DATE OF DEATH <u>July 8</u> Day Month Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 14, 1904</u>
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Own home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Columbus, Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Herbert (Unknown)</u>		14. MOTHER'S MAIDEN NAME <u>Louise (Unknown)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mr. Allen Gilliland</u> Address <u>1247 Winston</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Strangulation by hanging.</u> 974X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <input checked="" type="checkbox"/> (c) <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>Instant.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input checked="" type="checkbox"/> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hung herself from bath-room door, with curtain cord.</u>	
20c. TIME OF INJURY Hour o. p. <u>10:30 a.m.</u> p. m. <u>7/12/56</u> 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hosp.</u>	20f. (City or town) (County) (State) <u>Elliott City, Howard Co., Md.</u>
21. I certify that I attended the deceased from <u>10:30 a.m.</u> , 19 <u>56</u> , to <u>10:30 a.m.</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7/12/56</u> , and that death occurred at <u>10:30 a.m.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank E. Shipley</u> M.D. Physician's NAME (Type) <u>Frank E. Shipley, M.D.</u>		ADDRESS (Street, city or town, state) <u>Savage, Md.</u> DATE SIGNED <u>7/12/56</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>7/12/56</u>	22b. DATE THEREOF <u>7/12/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>SUNSET CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>Charlottesville, Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>L.J. Ruck, Inc.</u> ADDRESS <u>5305 Maryland Rd.</u>		24a. REC'D BY REGISTRAR <u>7/12/56</u>	24b. REGISTRAR'S SIGNATURE <u>G. E. Loughery</u>



CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES M. JONES		M		35		JUL 10 1921		BALTIMORE		MD		USA			
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
LABORER		HEART DISEASE		NATURAL		JUL 10 1956		BALTIMORE		MD		USA			
FAMILY PHYSICIAN		ATTENDING PHYSICIAN		DATE OF EXAMINATION		PLACE OF EXAMINATION		CITY		STATE		COUNTRY			
JAMES M. JONES		JAMES M. JONES		JUL 10 1956		BALTIMORE		MD		USA					
FAMILY PHYSICIAN		ATTENDING PHYSICIAN		DATE OF EXAMINATION		PLACE OF EXAMINATION		CITY		STATE		COUNTRY			
JAMES M. JONES		JAMES M. JONES		JUL 10 1956		BALTIMORE		MD		USA					

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JUL 10 1956  
BUREAU V. 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07267

7293

## CERTIFICATE OF DEATH

Reg. Dist. No.

191

1. PLACE OF DEATH o. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ridgewood Nursing Home</u>		d. STREET ADDRESS <u>3017 Mayfield Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Guarino</u> Last <u>Guarino</u>		4. DATE OF DEATH <u>July 30 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May, 11 1887</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret'd Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bethlehem Steel</u>	
11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Vincent Guarino</u>		14. MOTHER'S MAIDEN NAME <u>Mary</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Mrs. Carolina Guarino--3017 Mayfield Ave</u>	
17. INFORMANT <u>Mrs. Carolina Guarino--3017 Mayfield Ave</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardio Vascular Disease</u> DUE TO (c) <u>gem.</u>		INTERVAL BETWEEN ONSET AND DEATH. <u>See record</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>nine</u> , 19 <u>56</u> , to <u>July 30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>July 30</u> , 19 <u>56</u> , and that death occurred at <u>12 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William L. Fearing</u> M.D.		ADDRESS (Street, city or town, state) <u>3025 Belvoir Rd</u> DATE SIGNED <u>7-30 56</u>	
PHYSICIAN'S NAME (Type) <u>WILLIAM L. FEARING</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/2/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Rd.</u>		24a. REC'D BY REGISTRAR <u>31</u> DATE <u>31</u>	
		24b. REGISTRAR'S SIGNATURE <u>J. E. Leachman</u>	

AUG 1 1956

BUREAU V. S.

RECEIVED

7294

## CERTIFICATE OF DEATH

Reg. Dist. No.

191

1. PLACE OF DEATH a. COUNTY Howard County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Highland Manor Nursing Home				d. STREET ADDRESS Rockdale 03X-2			
3. NAME OF DECEASED (Type or print) First Nannie Middle Last Hambruch				4. DATE OF DEATH Month July Day 8 Year 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 5, 1879	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore County, Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Emily Geaslin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Thomas Costello - 2505 List Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Pulmonary Edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive Heart Failure (c) Arteriosclerotic Heart Disease							INTERVAL BETWEEN ONSET AND DEATH 5 months 1 yr 4 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from May 1955, to July 1956, that I last saw the deceased alive on 7/6 1956, and that death occurred at 5 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 5226 BALT NAT PARK 7/10/56 ACTUAL SIGNATURE Mary J Miller M.D. PHYSICIAN'S NAME (Type) MAX J Miller M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-11-56		22c. NAME OF CEMETERY OR CREMATORY Moreland Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. M. Cook, Inc.				ADDRESS 1217 St. Paul Street		24a. REC'D BY REGISTRAR DATE JUL 11 1956	
24b. REGISTRAR'S SIGNATURE John Laughlin							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		County	
Elliott, J. J.		Male		35		Sept. 1, 1892		Baltimore		Baltimore	
Cause of Death		Manner of Death		Place of Death		Date of Death		Time of Death		Signature of Physician	
Tuberculosis		Natural		Home		July 1, 1927		10:00 AM		J. J. Elliott	
Signature of Registrar		Signature of Coroner		Signature of Medical Examiner		Signature of Health Officer		Signature of Burial Officer		Signature of Undertaker	
J. J. Elliott		J. J. Elliott		J. J. Elliott		J. J. Elliott		J. J. Elliott		J. J. Elliott	

T. J. Elliott - 1927

BUREAU V. 8

JUL 11 1927

RECEIVED

Date of Death		Time of Death		Place of Death		Signature of Registrar	
July 1, 1927		10:00 AM		Home		J. J. Elliott	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07270

7295

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Keeton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Keeton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Woodbine P.O.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>EDWIN</u> Last <u>HATFIELD</u>		4. DATE OF DEATH Month <u>7</u> Day <u>11</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8 Feb 1889</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Automobile</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Eliza Hatfield</u>		14. MOTHER'S MAIDEN NAME <u>Katharine Evans</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or date of service)		16. SOCIAL SECURITY NO. <u>220-18-2024</u>	
17. INFORMANT <u>Amenda Hatfield</u>		Address <u>Woodbine, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> DUE TO <u>Cardiac Arrest, Congestive failure,</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral hemorrhage - Decubital ulcer</u> (c) <u>i hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>27 June 56</u> <u>11 July 56</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9 July</u> , 19 <u>56</u> , to <u>11 July</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11 July</u> , 19 <u>56</u> , and that death occurred at <u>9:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard E. Hall</u> M.D.		ADDRESS (Street, city or town, state) <u>Spersville, Md</u> DATE SIGNED <u>11 July 56</u>	
PHYSICIAN'S NAME (Type) <u>HOWARD E. HALL</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>7-14-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Jennings Chapel</u>	22d. LOCATION (City, town, or county) (State) <u>Howard Co, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. M. Waltz</u> ADDRESS <u>Winfield, Md.</u>		24. REC'D BY REGISTRAR <u>JUL 16 1956</u> REGISTRAR'S SIGNATURE <u>A. H. Hedrick</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
MARRIAGE		MARRIED		SINGLE		WIDOW		DIVORCED		SEPARATED		OTHER		DATE OF MARRIAGE		PLACE OF MARRIAGE	
EDUCATION		SCHOOL		COLLEGE		UNIVERSITY		OTHER		DATE OF DEATH		PLACE OF DEATH		CITY		STATE	
OCCUPATION		PROFESSION		VOCATION		INDUSTRY		OTHER		DATE OF DEATH		PLACE OF DEATH		CITY		STATE	
CAUSE OF DEATH		DISEASE		INJURY		POISON		OTHER		DATE OF DEATH		PLACE OF DEATH		CITY		STATE	
MANNER OF DEATH		NATURAL		ACCIDENT		SUICIDE		HOMICIDE		DATE OF DEATH		PLACE OF DEATH		CITY		STATE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		DATE OF DEATH		PLACE OF DEATH		CITY		STATE	

BUREAU V. S.

JUL 16 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the delay in writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. Prior to burial or cremation, file pages 1 and 2 with the registrar for a burial-transit permit. File pages 1 and 2 with the registrar for a burial-transit permit. File pages 1 and 2 with the registrar for a burial-transit permit.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

0726995

7296

1. PLACE OF DEATH a. COUNTY <b>Howard</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Middle Patuxent River + B.O.</b>		d. STREET ADDRESS <b>606 Tenth Street</b>	
3. NAME OF DECEASED (Type or print) <b>Charles Harcum</b>		4. DATE OF DEATH Month <b>7</b> Day <b>24</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-24-1917</b>
9. AGE (In years last birthday) <b>39</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>24</b> Hours <b>56</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>University of Md</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>Maryland</b>	
13. FATHER'S NAME <b>Clarence Harcum</b>		14. MOTHER'S MAIDEN NAME <b>Sadie Haines</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>yes</b>		16. SOCIAL SECURITY NO. <b>WW 2</b>	
17. INFORMANT <b>Mildred Harcum, Laurel, Md</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Accidental Drowning</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <b>929.8</b> DUE TO (a) stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell into flood waters of Middle Patuxent River</b>	
20c. TIME OF INJURY Hour <b>Unknown</b> o. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Middle Patuxent River, Laurel, Md</b>		20f. (City or town) (County) (State) <b>Howard</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Frank E. Shipley, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Frank E. Shipley M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-26-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. Selby, 401 Washington Blvd. Laurel, Md.</b>		24a. REC'D BY REGISTRAR <b>7/25/56</b>	
24b. REGISTRAR'S SIGNATURE <b>Frank Shipley</b>		DATE	

MEDICAL CERTIFICATION

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES J. JONES		45		M		W		JUL 20 1956		BOSTON, MASS.	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		CAUSE OF DEATH		MANNER OF DEATH	
1234 Main St., Boston, Mass.		Teacher		High School		Married		Heart Disease		Natural	
Physician		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Medical Examiner	
Dr. J. A. Smith		JUL 20 1956		10:00 AM		BOSTON, MASS.		J. A. Smith, M.D.		J. A. Smith, M.D.	

BUREAU V. S.

JUL 30 1956

RECEIVED

7297

## CERTIFICATE OF DEATH

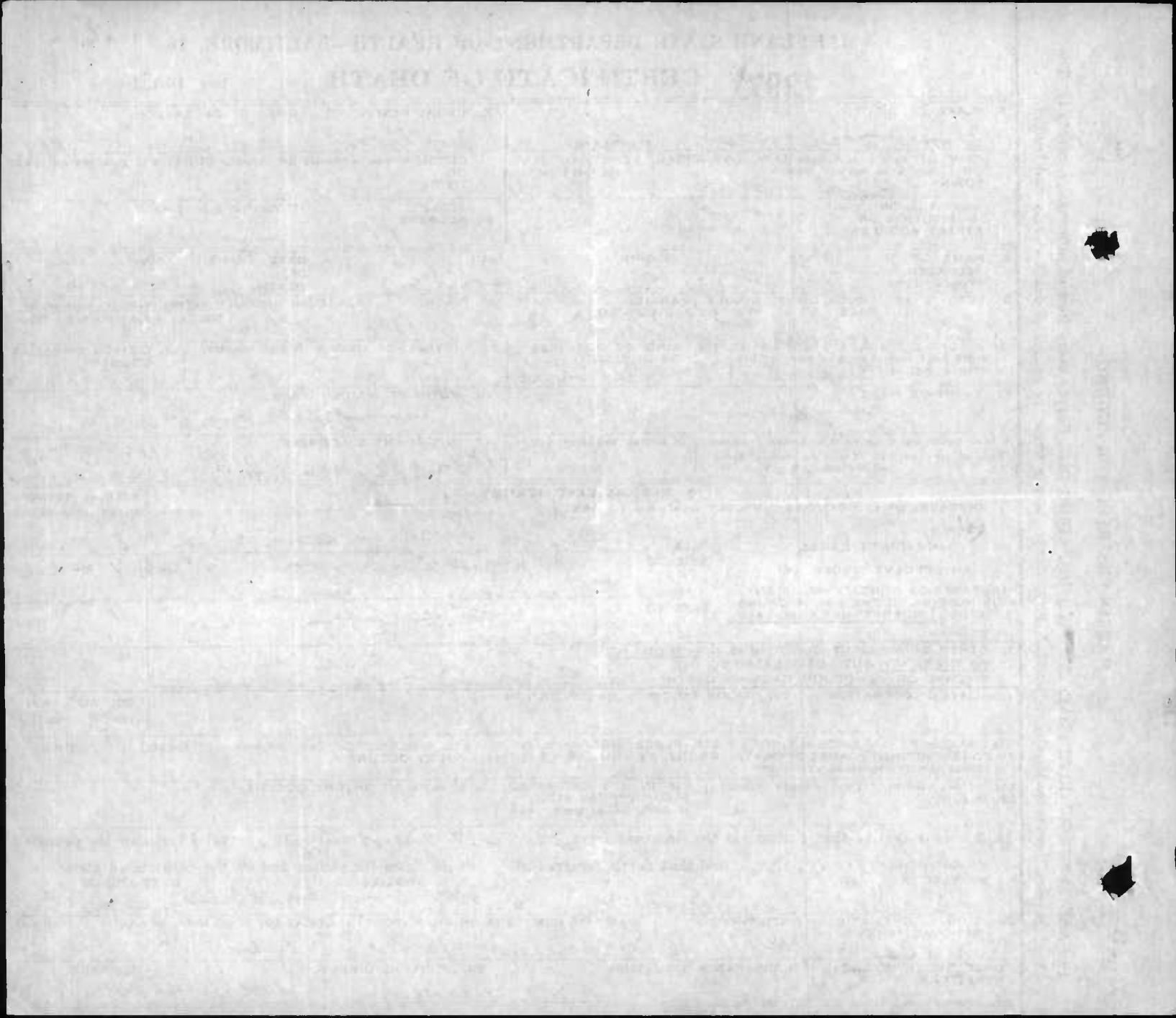
Reg. Dist. No. 190

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Howard</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		STREET ADDRESS (If rural give location)	
X <u>Elkridge</u>		<u>1 1/2 yrs</u>		X <u>Elkridge</u>		<u>1712 Levering ave</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1712 Levering ave</u>							
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year) OF DEATH:			
(First) (Middle) (Last) <u>Ludwig Karl Goepfer</u>				<u>July 12 1936</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>white</u>	<u>widow</u>	<u>Aug 4 1878</u>	<u>77</u> yrs.	<u>1</u> Months	<u>1</u> Days	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>Carpenter</u>				<u>W.D. R. R. Retired</u>		<u>Austria</u>	
12. CITIZEN OF WHAT COUNTRY?				<u>U.S.</u>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Unknown</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>no</u>						<u>Mrs Margaret Holley Elkridge</u> <u>1712 Levering</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.1 IMMEDIATE CAUSE				(A) <u>chr Myocarditis</u> <u>1 yr</u>			
ANTECEDENT CAUSE (S):				DUE TO <u>2 Decompensation</u> <u>1 mo</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.				(B) <u>General arterial</u> <u>5 yrs</u>			
				(C) <u>Sclerosis</u> <u>5-10 yrs</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<u>chr Arteritis</u> <u>15 yrs</u>							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
<u>0</u>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Dec</u> , 19 <u>35</u> , to <u>July 12</u> 19 <u>36</u> that I last saw the deceased alive on <u>July 11</u> , 19 <u>36</u> , and that death occurred at <u>3 a.m.</u> , from the causes and on the date stated above.							
SIGNATURE <u>B. B. Brumbaugh</u>				ADDRESS <u>5809 main st Elkridge</u>		DATE SIGNED <u>7/12/36</u>	
M. D. <u>MD</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>buried</u>		<u>July 14-36</u>		<u>Loudon Park</u>		<u>Frederick</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
				<u>Belmont</u>		<u>Box 164 Carroll</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7298

CERTIFICATE OF DEATH

07272

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Howard</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Highland</b>				c. LENGTH OF STAY IN 1b <b>3 Wks.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Simmons Rest Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Bertha Johnson</b>				4. DATE OF DEATH Month <b>July</b> Day <b>28</b> Year <b>19 56</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/27/76</b>	9. AGE (In years last birthday) <b>79</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Elizha Johnson</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Cavey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT Address <b>Mrs. Emma Howes Laytonsville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute heart failure</b> <b>420x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>260x</b> (b) <b>Coronary artery occlusion</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>5 mins</b> <b>5 mins</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus - 10 years</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 25, 1956</b> , to <b>July 28, 1956</b> , that I last saw the deceased alive on <b>July 25, 1956</b> , and that death occurred at <b>8:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Charles S. Whitaker</b> M.D.				PHYSICIAN'S NAME (Type) <b>CHARLES S. WHITAKER, M.D. CLARKSVILLE, MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/31/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Linthicum Chapel Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Clarksville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Roy W. Barber</b>				24a. REC'D BY REGISTRAR <b>Fogtownville</b>		24b. REGISTRAR'S SIGNATURE <b>Mario A. Whitaker</b>	

CERTIFICATE OF DEATH

2238

Name of Deceased <b>Johnnie Lee</b>		Sex <b>Male</b>		Age <b>25</b>		Date of Birth <b>Jan 15 1910</b>		Place of Birth <b>USA</b>	
Cause of Death <b>Heart Disease</b>		Manner of Death <b>Not Known</b>		Occupation <b>None</b>		Usual Residence <b>None</b>		Place of Death <b>None</b>	
Date of Death <b>Jan 15 1936</b>		Time of Death <b>10:00 AM</b>		Physician's Signature <b>Johnnie Lee</b>		Physician's Address <b>None</b>		Physician's Phone <b>None</b>	
Signature of Registrar <b>Johnnie Lee</b>		Signature of Medical Officer <b>Johnnie Lee</b>		Signature of Coroner <b>Johnnie Lee</b>		Signature of Undertaker <b>Johnnie Lee</b>		Signature of Burial Place <b>Johnnie Lee</b>	

BUREAU Y. 1

MIG 8 1936

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 Film 3200 7-25-56 et

Reg. Dist. No. 192

1. PLACE OF DEATH a. COUNTY <b>Howard</b> <b>7299</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodstock, Md.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodstock, Md.</b>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <b>Old Court Rd.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Old Court Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILEY</b> Middle <b>PURKEY</b> Last <b>PURKEY</b>		4. DATE OF DEATH Month <b>July</b> Day <b>16</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 2, 1918</b>
9. AGE (In years last birthday) <b>37</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	
11. BIRTHPLACE (State or foreign country) <b>Tenn</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Taylor Purkey</b>		14. MOTHER'S MAIDEN NAME <b>Lula Brewer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>411-28-7706</b>	
17. INFORMANT <b>Taylor Purkey, Sneedville, Tenn.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Extensive hemorrhage from laceration of left axilla involving axillary artery</b> 913.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>axilla involving axillary artery</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Impaled self on metal chair</b> 20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>7/15/56</b> p. m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>home</b> 20f. (City or town) (County) (State) <b>Woodstock Howard Md.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>William V. Lovitt, Jr.</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>William V. Lovitt, Jr., M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-19-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Davis</b>		22d. LOCATION (City, town, or county) (State) <b>Sneedville, Tenn.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md.</b>		24a. REC'D BY REGISTRAR <b>July 16</b>	
		24b. REGISTRAR'S SIGNATURE <b>Alfred J. Webb</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrars prior to burial, cremation, or removal.

RECEIVED

JUL 23 1956

BUREAU V. S.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12



7300

## CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH a. COUNTY <b>Howard</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>				c. LENGTH OF STAY IN 1b <b>Ellicott City</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <b>ALICE</b> Middle <b>MAY</b> Last <b>RAMSBURG</b>				4. DATE OF DEATH Month <b>July</b> Day <b>29</b> Year <b>1956</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 20 1866</b>	9. AGE (In years last birthday) <b>90 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Frederick Co. Md</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Thomas Dronenburg</b>				14. MOTHER'S MAIDEN NAME <b>? Burrier</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Alva Ramsburg, Ellicott City, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <b>Arteriosclerotic Cardio-Vascular Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>						INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>4 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 2, 1950</b> to <b>July 29, 1956</b> , that I last saw the deceased alive on <b>July 27, 1956</b> , and that death occurred at <b>8 A. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>William F. Gassaway</b> M.D.				ADDRESS (Street, city or town, state) <b>Ellicott City, Md.</b>			
DATE SIGNED <b>7/29/56</b>							
PHYSICIAN'S NAME (Type) <b>William F. Gassaway M.D.</b> <b>Ellicott City, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-31-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Johns</b>		22d. LOCATION (City, town, or county) (State) <b>Ellicott City, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md</b>				24a. REC'D BY REGISTRAR DATE <b>July 31, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>John B. Loughran, Jr.</b> <b>B. E. L.</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07275

7321

## CERTIFICATE OF DEATH

Reg. Dist. No. 194

1. PLACE OF DEATH a. COUNTY <b>Howard</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> o. STATE <b>D.C.</b> b. COUNTY <b>16X-2</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fulton</b>				c. LENGTH OF STAY IN 1b <b>1 year</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Simons Rest Home</b>				d. STREET ADDRESS <b>5205 Hamlet Street</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Annie Elizabeth Robey</b>				4. DATE OF DEATH Month Day Year <b>July 3 1956</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 4, 1868</b>	9. AGE (In years last birthday) yrs. <b>87</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Hugh Davis</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Mrs. Delilah Simons, Fulton, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic myocardial failure</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>6 weeks</b> <b>15 years</b>						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 1955</b> , to <b>July 3 1956</b> , that I last saw the deceased alive on <b>July 2 1955</b> , and that death occurred at <b>1:00 PM</b> , from the causes and on the date stated above. <b>Charles S. Whitaker</b> ADDRESS (Street, city or town, state) DATE SIGNED <b>7/4/56</b>							
ACTUAL SIGNATURE <b>Charles S. Whitaker, M.D.</b>							
PHYSICIAN'S NAME (Type) <b>Charles S. Whitaker, M.D.</b> <b>Clarksville, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>7-6-1956</b>		<b>Cedar Hill</b>		<b>Smithland bpd</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Robert C. Mattingly 131-11th St E</b>				24a. REC'D BY REGISTRAR DATE <b>7/6/56</b>		24b. REGISTRAR'S SIGNATURE <b>Marie C. Whitaker</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		John J. Jones	
Sex		Male	
Age		7 years	
Date of Birth		October 10, 1948	
Place of Birth		Baltimore, Md.	
Usual Residence		1234 North Street, Baltimore, Md.	
Cause of Death		Sudden Infant Death Syndrome	
Date of Death		October 15, 1955	
Place of Death		Home	
Occupation		None	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Date of Registration		October 16, 1955	
Place of Registration		Baltimore, Md.	

BUREAU V. S.

OCT 10 1955

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OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4  
ned by the hospital or attending physician.  
DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the funeral director, by the funeral director, or by the health officer. Pages 1 and 2 should be filled with the information required. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7302  
CERTIFICATE OF DEATH

07276

Reg. Dist. No.

191

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Schafer Conv. &amp; Retreat Home</u>		d. STREET ADDRESS <u>4219 E. KENWOOD ST.</u>	
3. NAME OF DECEASED (Type or print) <u>Mr. JOHN W. Senner</u>		4. DATE OF DEATH <u>July 9th 1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 17, 1872</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINIST Ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CAN MFR.</u>	9. AGE (In years last birthday) <u>83</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GEORGE Senner</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-03-3693</u>	
17. INFORMANT <u>Mr. Arthur W. Senner</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE PULMONARY EDEMA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CARDIAC DECOMPENSATION</u> DUE TO (c) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>2 HRS</u> <u>2 YRS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7-7</u> , 19 <u>56</u> , to <u>7-7</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7-7-56</u> , 19 <u>56</u> , and that death occurred at <u>2:25 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Peter V. Thorpe</u>		ADDRESS (Street, city or town, state) <u>COLUMBIA ROAD, ELLICOTT CITY, MD.</u>	
PHYSICIAN'S NAME (Type) <u>PETER V. THORPE, MD</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/12/1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck, 5305 Hartford Road #14</u>		24a. REC'D BY REGISTRAR <u>July 13, 1956</u>	24b. REGISTRAR'S SIGNATURE <u>J. E. Loughran</u>



CERTIFICATE OF DEATH

NAME OF DECEASED <i>George A. Jones</i>		DATE OF DEATH <i>July 1, 1956</i>	
PLACE OF DEATH <i>Home</i>		AGE <i>65</i>	
SEX <i>Male</i>		RACE <i>White</i>	
MARRIAGE <i>Married</i>		EDUCATION <i>High School</i>	
OCCUPATION <i>Retired</i>		RELIGION <i>Methodist</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>	
DATE OF DEATH <i>July 1, 1956</i>		TIME OF DEATH <i>10:30 AM</i>	
PLACE OF DEATH <i>Home</i>		ADDRESS <i>123 Main St, City, State</i>	
NAME OF DECEASED <i>George A. Jones</i>		DATE OF DEATH <i>July 1, 1956</i>	
PLACE OF DEATH <i>Home</i>		AGE <i>65</i>	
SEX <i>Male</i>		RACE <i>White</i>	
MARRIAGE <i>Married</i>		EDUCATION <i>High School</i>	
OCCUPATION <i>Retired</i>		RELIGION <i>Methodist</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>	
DATE OF DEATH <i>July 1, 1956</i>		TIME OF DEATH <i>10:30 AM</i>	
PLACE OF DEATH <i>Home</i>		ADDRESS <i>123 Main St, City, State</i>	

BUREAU V. S.

JUL 16 1956

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7303

## CERTIFICATE OF DEATH

Reg. Dist. No. 195

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Howard</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Cc</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Jessups Md</u>		LENGTH OF STAY (in this place) <u>6 hrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Jessups Md</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>100</u>				STREET ADDRESS (If rural give location) <u>Unknown Rd</u>			
3. NAME OF DECEASED: (Type or Print) <u>Carolyn</u> (First) <u>Virginia</u> (Middle) <u>Thomas</u> (Last)				4. DATE (Month) (Day) (Year) OF DEATH: <u>7/20/56</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>Col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>SINGLE</u>	8. DATE OF BIRTH: <u>JULY 20, 1956</u>	9. AGE last birthday <u>6</u> yrs.	10. UNDER 1 YEAR Months Days	11. UNDER 24 HRS. Hours Min.	12. CITIZEN OF WHAT COUNTRY? <u>6</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>NONE</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>NONE</u>		11. BIRTHPLACE (State or foreign country): <u>Jessups Md.</u>	
13. FATHER'S NAME: <u>Allen Eugene Thomas</u>				14. MOTHER'S MAIDEN NAME: <u>Sarah Ellen Wilson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u> If Yes, give war or dates of service				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS: <u>A.E. Thomas, Jessups Md</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
176X IMMEDIATE CAUSE (A) <u>Premature birth</u>						6 hrs	
ANTECEDENT CAUSE (S):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B)							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from , 19 , to , 19 , that I last saw the deceased alive on , 19 , and that death occurred at M, from the causes and on the date stated above							
SIGNATURE <u>John J. Paulding</u>				ADDRESS <u>Rd Box 212 Edmonds Md</u> DATE SIGNED			
M. D. <u>7-21-56</u>							
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> DATE THEREOF <u>7-21-56</u>				NAME OF CEMETERY OR CREMATORY <u>Hopkins Chapel</u>		LOCATION (City, town, or county) (State) <u>Nightland Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7/24/56</u>				REGISTRAR'S SIGNATURE <u>Frank Shipley</u>		24. FUNERAL DIRECTOR ADDRESS <u>200 N. E. 1st St, Elenor City Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 26 1956

RECEIVED